QUARTERLY REPORT
VERIFICATION OF SUPERVISION PROVIDED DURING WAIVER PERIOD

Quarter Beginning _____Date of Submission: _____

Quarter Ending: _____Employee # _____

Name: _____

Work Location: _____

Address: _____

Telephone No. _____

Service Delivery Supervisor _____Discipline: _____

Address: _____

Telephone No. _____

Total hours of <u>Service Delivery</u> Supervision provided this quarter:
_____

Total Supervised Hours provided this quarter:
_____

Factors having potential impact on Waiver period: _____

☐ None

☐ Change in Service Delivery Supervisor Date: _____

☐ Leave of Absence Date began: _____ Date ended: _____

☐ Extended Medical Leave Date began: _____ Date ended: _____

☐ Transfer to non-service delivery program Date: _____

☐ Completed supervised hours for licensure Date: _____

☐ Other

Worker needs additional Training/Experience Yes No

If yes, please explain: _____

_____

Signature of Service Delivery Supervisor: _____ Date _____

Please forward form to County of Los Angeles Department of Mental Health
550 S. Vermont Ave., Los Angeles, CA 90020, Attn Training Division